SCITUATE PODIATRY GROUP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____

Patient Name (please print) **Date of Birth**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

I AUTHORIZE SCITUATE PODIATRY TO DISCLOSE MY MEDICAL INFORMATION TO THE **FOLLOWING FAMILY MEMBERS/FRIENDS:**

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone & mail) by Dr. Count, Dr. Lawrence, Dr. Southard, and/or staff be handled in the following manner:

For Oral Communications: **&** **For Written Communications:**

Phone# _____ Address : _____

_____

May we leave a message regarding appointments? _____

____ Yes ____ No

If the address provided above is not your home address **or** is not a street address, please provide us with a mailing address for purpose of ensuring payment:

_____

_____

_____

SIGNATURE_____ DATE _____